IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 14, 2007

Maggie Pavelek, Administrator
Regency Columbia Village, LLC
3521 E Lake Forest Dr
Boise, ID 83716

License #: RC-787

Dear Ms. Pavelek:

On November 15, 2007, a complaint investigation survey was conducted at Regency Columbia Village, LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Donna Henscheid, LSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Donna Henscheid

DONNA HENSCHEID, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DH/sc

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November 27, 2007

CERTIFIED MAIL #: 7005 1160 0000 1506 7915

Maggie Pavelek, Administrator
Regency Columbia Village, LLC
3521 E Lake Forest Dr
Boise, ID 83716

Dear Ms. Pavelek:

Based on the complaint investigation survey conducted by our staff at Regency Columbia Village, LLC on **November 15, 2007,** we have determined that the facility failed to protect residents from inadequate care. Based on observatioin, interview and record review it was determined the facility failed to provide sufficient supervision to meet the needs for 1 of 5 sampled residents (#5) and had the potential to affect 100% of the residents in the facility.

This core issue deficiency substantially limits the capacity of Regency Columbia Village, LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **December 30, 2007.** **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **December 10, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**December 10, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **December 10, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **December 15, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Regency Columbia Village, LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Progran Supervisor
Residential Community Care Program

JS/sc

Enclosure

c: Lynne Denne, Program Manager, Regional Medicaid Services, Region IV - DHW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R787	A. BUILDING _____ B. WING _____	C 11/15/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY COLUMBIA VILLAGE, LLC	3521 E LAKE FOREST DR BOISE, ID 83716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the complaint investigation conducted at your residential care/assisted living facility. The surveyors conducting your complaint survey were: Team Coordinator Donna Henscheid, LSW Health Facility Surveyor Rachel Corey, RN Health Facility Surveyor Definitions: ASAP = as soon as possible cm = centimeter EMT = emergecy medical technician HH = home health hr. = hour OOB = out of bed pt. = patient q = every RN = Registered Nurse	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide sufficient supervision to meet the needs for 1 of 5 sampled residents (#5) and had the	R 008		

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R 008	Continued From page 1 potential to affect 100% of the residents in the facility. The findings include: SUPERVISION Supervision as defined in IDAPA 16.03.22.012.25 is: "a critical watching and directing activity which provides protection, guidance, knowledge of the resident's general whereabouts and assistance with activities of daily living. The administrator is responsible for providing appropriate supervision based on each resident's Negotiated Service Agreement or other legal requirements." Resident #5 was admitted to the facility on 8/1/07 with the following diagnoses: recurrent glioblastoma, right frontal lobe; left hemiparalysis; progressive left-sided weakness and complaints of headaches. 1. Transfers A resident service note dated 9/7/07 documented Resident #5 had increased right-sided weakness and had become a two person transfer. It also documented the facility RN would discuss with the family the possibility of the facility no longer being able to care for the resident. An Incident/Accident Report dated 9/22/07 documented the following: "Went to get resident up for lunch. Resident unable to stand/transfer. Let resident rest, then tried again. After fifth try, resident was sliding off edge of bed. [Aid's name from another HH agency] came in and helped me lower resident to the floor. Both of us tried to lift but we were unsuccessful. Called [staff member's name] about possibly having a gait belt. She came over, all three of us tried to get resident up, but were unsuccessful. Had to call for fire dept. to	R 008		

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R 008	Continued From page 2 lift resident from floor to her wheelchair. Resident is very weak w/little to know [sic] use of her right side and no use of her left side. Speech is weak and sometimes garbled. I called her sister-in-law and her brother. They came and transferred her to her bed. Due to her physical inability, we all decided to keep her in bed." A Hospice Services Initial Assessment dated 9/27/07 documented Resident #5 was "rapidly becoming bedbound" and under the Safety Section it documented, "Brother stated it was nearly impossible for anyone but himself to get pt. safely up and out of bed." A Hospice Service Note dated 10/05/07 documented Resident #5 had "lost abilities to walk. Growing more dependent quickly. Facility RN requests gait belt. Will bring next visit. Pt is very difficult transfer. Mainly in bed." A hospice visit note dated 11/1/07 documented that staff had transferred resident to the toilet. "Discussed safety for all. Will use bedpan from now on." A resident note dated 11/2/07 documented the family was informed of the "trouble" the facility was having transferring Resident #5 and that a Hoyer lift was going to be ordered and a bed pan used "all the time." A "Documentation By Exception" form dated 11/08/07 documented Resident #5, "...has Hoyer lift, we will have training." A nursing assessment dated 11/9/07 documented, "Will start using Hoyer lift to get OOB and to promote comfort and safety, turn q 2 hr. while in bed."	R 008		

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R 008	Continued From page 3 The September staffing schedule documented there was only one staff scheduled from 6:00 PM to 6:00 AM in Resident #5's building. The October staffing schedule documented there was only one staff scheduled from 6:00 PM to 6:00 AM in Resident #5's building. On 11/14/07 at 9:15 AM the caregiver stated Resident #5 was difficult to transfer so staff were not getting her out of bed. The caregiver stated the resident had a Hoyer lift in her room but she hadn't used it yet. The caregiver stated, "I know we're having a training on it. I don't know how often other caregivers are using the Hoyer lift or if they are." On 11/14/07 at 11:15 AM the facility RN stated Resident #5 was a two-person assist with transfers and at night time there was not enough personnel to provide a two person transfer. The facility RN stated, "there is only one person in each house at night. The resident does require a Hoyer lift for transfers and training for the staff was arranged for November 19, 2007." On 11/14/07 at 11:45 AM the administrator confirmed the Hoyer lift training had not been done but needed to occur, "ASAP". On 11/14/07 at 3:30 PM a hospice RN stated Resident #5 was "incontinent of stool and moving her was very difficult. The hospice RN stated there was no medical reason the resident could not be out of bed which is why a Hoyer lift was ordered. The hospice RN also stated the hospice physical or occupational therapist were going out to do the Hoyer training but were waiting for an order. Further, the hospice RN stated she was	R 008		

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R 008	Continued From page 4 there during a transfer when the EMTs had to be called. The hospice RN stated Resident #5 asked to get up to the commode. The resident was transferred to the commode with such difficulty, the RN recommended the EMTs be called for assistance with the transfer back to bed because of safety. On 11/14/07 at 4:05 PM the administrator stated the facility was unable to provide two staff from 12:30 AM to 6:00 AM. On 11/14/07 at 4:05 PM the facility RN stated that during the day there were enough staff available to get Resident #5 up and questioned why the resident could not be left in bed during the time when there was only one staff. From September to November 2007, for approximately 9 weeks, the facility did not provide adequate supervision to meet Resident #5's care needs to provide her with safe transfers. The resident's health declined and on 9/7/07 it was documented the resident became a two-person transfer and only one staff member worked in the building from 12:30 PM to 6:00 AM. Although a Hoyer lift was ordered on 11/8/07, it was not being used because the staff had not been trained. As a result of this, Resident #5 was confined to her bed. 2. Positioning A. Turn schedule/skin breakdown A resident service note dated 9/7/07 documented Resident #5 had increased right-sided weakness. A hospice Initial Plan of Treatment and Certification form dated 9/27/07 documented the	R 008		

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R 008	Continued From page 5 aids were to float the resident's heels and turn every 2 hours. Hospice Services Initial Assessment dated 9/27/07 documented Resident #5 was "rapidly becoming bedbound" and under the "Teaching/Intervention" section, it documented "turn q 2 hours." Under the "Caregiver" section, it documented the caregivers "did need instruction and support for bedbound pt. Instructed in skin care." A hospice visit note date 10/22/07 documented Resident #5 had two 1 cm x 1 cm stage II decubiti in the crease of the coccyx. A resident service note dated 10/25/07 documented Resident #5 was to be "propped" every two hours during the day and twice at night. It also documented the resident was "spending too much time on her back" and had two bedsores which needed to heal. A nursing assessment dated 11/9/07 documented Resident #5 had a Foley catheter in place and had a "decub" on sacrum which was healing. It further documented, "to promote comfort and safety, turn q 2 hr. while in bed." On 11/14/07 at 8:52 AM a caregiver stated, "I don't know if Resident #5 is on a turn schedule or not. Hospice comes in and cares for her." The caregiver showed the surveyors a "Care Book" which documented Resident #5 was to be turned 4 times a day. The caregiver stated, "I haven't turned her yet but I will when I go into deliver her breakfast." On 11/14/07 at 9:10 AM the resident was observed laying flat on her back at a 20 degree	R 008		

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R 008	Continued From page 6 angle and the caregiver raised the bed to a 45 degree angle. The caregiver was not observed to turn the resident. On 11/14/07 at 10:16 AM Resident #5 was observed to be laying on her back. The caregiver was not observed to reposition or turn the resident. On 11/14/07 at 11:15 AM the facility RN stated Resident #5 was on a turn schedule which was put in the Care Book. The RN stated the resident was to be turned every 2 hours. The facility RN was not aware the Care Book did not reflect the 2 hour turn schedule. On 11/14/07 at 11:45 AM the administrator confirmed the resident was to be turned every two hours but was unaware the Care Book did not reflect the two hour turn schedule. On 11/14/7 at 12:15 PM a hospice caregiver stated, "A week ago I repositioned Resident #5 after giving her a shower and changed her clothes. I put a towel under her arm and floated her heels. This was on a Monday and on Wednesday when I came to bathe her, she was in the same clothes, the same towel was under her arms and the same pillows under her legs. Also on that Monday, I had put her last pull-up attends on and on Wednesday, she was wearing the same one." On 11/14/07 at 12:35 PM the Care Coordinator was observed to attempt to raise Resident #5 to a more upright position by wrapping her arms around the resident and placing pillows behind the resident's back. The Care Coordinator was observed to struggle to keep the resident upright while trying to place the pillows behind her back	R 008		

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R 008	Continued From page 7 as the resident was not able to participate in moving herself. The Care Coordinator left the room and came back with the RN and a hospice caregiver to assist her with the repositioning. They were observed to lay the bed out flat and used the drawsheet to boost the resident up. They raised her head up to a 90 degree angle. On 11/14/07 at 3:30 PM a hospice RN confirmed the Resident #5 had stage II pressure ulcers but stated they were "healing." The hospice RN also stated the catheter was considered because Resident #5's "potential for skin breakdown was grave related to incontinence and moving her was very difficult." The facility did not provide adequate supervision to meet the resident's care needs for turning or repositioning. The resident had left-sided hemiparalysis and increased right-sided weakness and the resident was unable to reposition herself in bed. Hospice recommended the resident be turned every 2 hours to prevent skin breakdown. The staff did not receive the appropriate direction or training regarding a turn schedule or bed positioning which contributed to the development of two decubitus pressure ulcers. B. Positioning during eating. On 11/14/07 at 8:00 AM Resident #5 was observed laying on her back in bed at a 15 degree angle. A medication aide raised the head of the bed to a 45 degree angle. The medication aide placed a cup of applesauce with medications in it at the bedside table in front of the resident. The medication aide handed the resident a spoon and the resident spooned the applesauce with medications into her mouth.	R 008		

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R 008	Continued From page 8 On 11/14/07 at 9:10 AM the caregiver was observed to bring Resident #5 a tray of food. The resident was observed laying flat on her back at a 20 degree angle. The caregiver raised the head of the bed to a 45 degree angle and arranged the tray in front of the resident on the bedside table. The bedside table was approximately a foot away from the resident just above the resident's nose level. The caregiver left the room and the resident was observed to slowly spoon the oatmeal into her mouth, spilling the oatmeal on her nightgown as she ate. On 11/14/07 at 8:52 AM a caregiver stated, "I believe she (Resident #5) feeds herself but am not sure because I haven't worked in this building much." On 11/14/07 at 11:45 AM the administrator and Care Coordinator stated they were unaware the staff were not raising the resident to an upright position for eating. The facility did not provide adequate supervision to meet Resident #5's care needs for positioning during meals. The resident had left-sided hemiparalysis and increased right-sided weakness and the resident became more difficult to reposition or transfer from the bed. Therefore, the facility was not getting the resident up for meals and the staff did not receive direction or training regarding appropriate positioning to facilitate safe nutritional intake. The facility did not provide supervision to ensure that all staff were knowledgeable regarding Resident #5's care needs. The facility did not ensure the resident's health, safety and comfort	R 008		

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R 008	Continued From page 9 was provided for at all times by providing assistance with transferring, interventions to prevent skin breakdown and appropriate positioning during meals. These failures resulted in inadequate care.	R 008		

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November 27, 2007

Maggie Pavelek, Administrator
Regency Columbia Village, LLC
3521 E Lake Forest Dr
Boise, ID 83716

Dear Ms. Pavelek:

On November 15, 2007, a complaint investigation survey was conducted at Regency Columbia Village, LLC. The survey was conducted by Rachel Corey, RN and Donna Henscheid, LSW. This report outlines the findings of our investigation.

Complaint # ID00003105

Allegation #1: Staff were not using proper infection control techniques during resident treatments.

Findings: Based on observation it was determined that staff were not using proper infection control techniques during resident cares.

On November 14, 2007 at 9:00 a.m., a caregiver was observed emptying a Foley catheter bag. During the process, the caregiver did not wear gloves. After emptying the catheter bag, the caregiver rinsed her hands under running water, turned off the faucet, then shook her hands off without drying them.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.335.03 for not utilizing universal precautions when caring for residents. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: Residents with dementia have missed meals because staff did not provide trays to residents not at the dining room.

Findings: Based on observation and interview, it was determined that an identified resident missed breakfast, because staff did not bring a breakfast tray into the resident's room.

On November 14, 2007 between 8:15 a.m. and 10:20 a.m., it was observed an indentified resident with dementia was not provided with breakfast, as a tray was not brought into the resident's room.

On November 14, 2007 at 8:52 a.m., a caregiver stated that the identified resident did not want to eat, so a tray was not brought to her room.

On November 14, 2007 at 9:00 a.m., the medication aid stated that the identified resident would frequently refuse meals, but would eat if food was brought to her room.

On November 14, 2007 a.m., the hospice caregiver stated she hadn't observed a breakfast tray brought into the resident's room.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for not implementing the negotiated service agreement to provide three meals to the resident. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: Unlicensed staff were administering insulin injections.

Allegation: Based on observation, interview and record review, it could not be determined that unlicensed staff were administering insulin injections.

On November 14, 2007 at 7:45 a.m., the medication aid stated that only one resident required insulin. She stated the indentified resident required assistance from caregivers with rolling down the waist band of her pants, but would inject the insulin independently.

On November 14, 2007 at 7:49 a.m., the indentified resident stated that staff bring a pre-filled insulin syringe to her and holds her pants away from her stomach while she injects the insulin independently.

On November 14, 2007 a nursing assessment dated 9/20/07, documented the indentified resident was capable of safely self injecting insulin.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #4: Residents' rights to a sanitary environment were not protected, as residents' rooms were dirty.

Allegation: Based on observation, interview, and record review, it could not be determined that resident's rooms were not cleaned appropriately.

On November 13, 2007 through November 15, 2007, observations were made of the facility common areas and of all resident rooms. Rooms were observed to be clean and well kept. During the resident room tour, no residents complained about the cleanliness of rooms when interviewed.

On November 14, 2007, the resident council meeting notes were reviewed and there was no documentation found related to complaints about the cleanliness of the facility.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Donna Henscheid

DONNA HENSCHEID, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DH/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Donna Henscheid, LSW, Health Facility Surveyor

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HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

November 27, 2007

Maggie Pavelek, Administrator
Regency Columbia Village, LLC
3521 E Lake Forest Dr
Boise, ID 83716

Dear Ms. Pavelek:

On November 15, 2007, a complaint investigation survey was conducted at Regency Columbia Village, LLC. The survey was conducted by Rachel Corey, RN and Donna Henscheid, LSW. This report outlines the findings of our investigation.

Complaint # ID00003232

Allegation #1: Food was served cold.

Findings: Based on observation, interview and record review, it was determined that food was served cold to residents. However, the facility was determined to have corrected the problem.

On November 13, 2007 at 3:15 p.m., a sampled resident stated vegetables and pasta were frequently served cold until two weeks ago when the facility began warming the plates before distributing meals from the central kitchen to the different buildings of the facility.

On November 14, 2007, resident council meeting notes were reviewed from May 31, 2007 until September 27, 2007. The notes documented consistent complaints about the temperature of the food being served to residents. However, the council notes dated September 27, 2007, documented residents had appreciated the response of management and the cook in addressing the the previous complaints about the serving temperature of meals delivered to residents.

On November 14, 2007 at 12:15 p.m., the temperature of turkey directly from the oven was found to be appropriate at 220 degrees. Additionally, the turkey and mashed potatoes after being transferred to plates and placed in a transfer cart to be delivered to residents, was found to be appropriate at 170 degrees.

On November 14, 2007 at 12:42 p.m., 4 random residents eating lunch at the dining room stated that food was the appropriate temperature.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by correcting the problem by warming plates before transferring food to residents.

Allegation #2: The facility was not following physician's orders in regards to an indentified resident's ted hose application.

Findings: Based on observation, record review and interview it could not be determined that the facility did not follow physician's orders in regards to an indentified resident's ted hose application.

On October 13, 2007 at 3:15 p.m., an indentified resident was observed with her ted hose on and she stated that a caregiver assisted her with applying them at 7:30 a.m. that morning. She stated that staff always assisted her to apply ted hose but not at consistent times in the morning.

On October 14, 2007 an order by the physician dated March 13, 2007, document "Please assist patient in putting on compression stockings."

On October 14, 2007 at 3:52 p.m., the identified resident stated she was assisted with ted hose application that morning at 9:20 a.m. by the medication aid.

On October 14, 2007 at 3:59 p.m., a caregiver stated ted hose was routinely applied to the indentified resident when assisting the resident to get ready for breakfast and was taken off before bed time each day.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #3: Staff were not trained on how to safely transfer residents from a bed or wheelchair.

Findings: Based on interview and record review, it was determined staff were not appropriately trained in resident transfers utilizing a Hoyer lift.

On November 14, 2007 an incident report dated September 22, 2007, was reviewed and documented the identified resident was lowered to the floor during an unsuccessful transfer from the resident's bed to the wheelchair. The report further documented that when the family was notified of the incident they came to transfer the resident back to bed from the floor.

On November 14, 2007 at 9:10 a.m., a caregiver stated the identified resident required a Hoyer lift for transfers. She further stated that she had not been trained in the use of the Hoyer lift and thus had not transferred the resident yet.

On November 14, 2007 at 11:45 a.m., the administrator confirmed Hoyer lift training had not been done. She stated training was scheduled for November 19, 2007, but acknowledged training should be done sooner since a Hoyer lift was required to safely transfer the indentified resident.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for inadequate care. The facility was required to submit a plan of correction.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Donna Henscheid

DONNA HENSCHEID, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DH/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Donna Henscheid, LSW, Health Facility Surveyor

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November 27, 2007

Maggie Pavelek, Administrator
Regency Columbia Village, LLC
3521 E Lake Forest Dr
Boise, ID 83716

Dear Ms. Pavelek:

On November 15, 2007, a complaint investigation survey was conducted at Regency Columbia Village, LLC. The survey was conducted by Rachel Corey, RN and Donna Henscheid, LSW. This report outlines the findings of our investigation.

Complaint # ID00003277

Allegation #1: Appropriate care was not provided to meet the needs of an indentified resident.

Findings: Based on observation, interview and record review, it was determined that appropriate care was not provided to meet the needs on an indentified resident.

Observations were made on November 14, 2007 between 8:00 a.m. and 3:35 p.m. of the indentified resident. During this time, the resident was not observed to have been turned or transferred out of bed. Additionally, the resident was not observed to have been positioned appropriately for meals, as the head of the bed was not in an upright position. Further, staff confirmed the resident required a Hoyer lift for transfers, but stated they were not trained on how to use it. Finally, the caregiver providing cares during this time period was unsure whether the resident required a turning schedule or needed assistance with eating. Refer to full 2567 report for further details.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing appropriate care which resulted in inadequate care. The facility was required to submit a plan of correction.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Donna Henscheid

DONNA HENSCHEID, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DH/sc

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Regency Columbia Village, LLC	3521 E. Lake Forest Dr.	208-344-2954
Administrator	**City**	**ZIP Code**
Maggie Pavelek	Boise	83716
Survey Team Leader	**Survey Type**	**Survey Date**
Donna Henscheid	Complaint	11/15/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	320.01	The NSA was not implemented for Resident #4 to meet her dietary needs. i.e. a breakfast tray was not brought to Resident.		
2	320.02.p	The NSAs for Residents # 1, 3, 4 & 5 did not clearly describe the services provided by outside agencies		
3	320.08	The NSAs for Residents # 1, 3, 4 & 5 were not updated to accurately describe their care needs following a change in condition. Resident #2's NSA was not updated after 12 months. (Res # 2 COS)		
4	335.03	Staff did not use Universal Precautions when providing catheter care. i.e. use of gloves & washing hands.		

Response Required Date	Signature of Facility Representative	Date Signed
12/15/07	[signature]	11/19/07